INITIAL DISABILITY CLAIM FORM

Failure to complete this form in its entirety may result in a delay in processing this claim.

FILING CLAIM FOR (check all that apply)**:**

☐ Disability due to an Accident ☐ Disability due to a Sickness ☐ Disability due to Pregnancy / Complications ☐ Disability due to Cancer

Cancer Policy Number	Accident Policy Number	Short-Term Disability/ Sickness Rider Policy Number	Hospital Indemnity Policy Number	Hospital Intensive Care Policy Number	Life Policy Number

INSTRUCTIONS: **Be sure to include your policy number(s) on all documents.**

- ☐ Complete and sign **Section A: Policyholder/Patient Information**.
- ☐ Your employer should complete and sign **Section B: Employer's Statement.**
- ☐ Your physician should complete and sign **Section C: Physician's Statement**.
- ☐ This form should be completed on or after the initial date of your disability, hospitalization, and/or surgery. Forms completed prior to the initial date of your disability, hospitalization, and/or surgery, may result in a delay in processing this claim.
  If you are a contract, 1099, or self-employed worker, please submit your prior-year tax return (Schedule C) and current-year estimated tax payments (1040ES).
- ☐ If hospitalized and/or confined to an intensive care unit/step-down unit, please send a copy of your hospital bill showing charges and the number of days you were confined. These items can be obtained directly from your health care provider(s) by requesting a UB04 (hospital bill) or HCFA1500 (nonhospital bill).
- ☐ Please include a certified copy of the death certificate if the patient is deceased.
- ☐ This claim form should be completed on or after the initial date of your disability, hospitalization, and/or surgery. Forms completed prior to the initial date may result in a delay in processing this claim.

SECTION A: POLICYHOLDER INFORMATION (please print)

First Name _____ Initial _____ Last Name _____

Mailing Address _____

City _____ State _____ ZIP _____

Check box if this is a new permanent address: ☐

Social Security Number _____ Phone Number _____

PATIENT INFORMATION (please print)

First Name _____ Initial _____ Last Name _____

Relationship: ☐ Primary Policyholder ☐ Spouse

Sex: ☐ Male ☐ Female

Patient Date of Birth: ____/____/____

First date work missed for this disability: ____/____/____

Have you returned to work at any job? ☐ Yes ☐ No

If due to an accident, please give date, details, and location of the accident.

Date of Incident: ____/____/____

Describe where and how the incident occurred: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

CLAIMANT SIGNATURE _____ FAMILY RELATIONSHIP, IF NOT POLICYHOLDER _____ DATE _____

American Family Life Assurance Company of Columbus (Aflac)
Attention: Claims Department • Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
For information or help filing your claim, please call toll-free or visit our Web site at aflac.com
Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

INITIAL DISABILITY CLAIM FORM – EMPLOYER'S STATEMENT

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Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

Policy Number: Policyholder's Name: _____

Patient Name: _____ Date of Birth: _____

SECTION B: EMPLOYER'S STATEMENT

EMPLOYER'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )
MAILING ADDRESS	CITY	STATE ZIP

1. First date of disability: _____ /_____ /_____

2. Was this disability caused by an incident that occurred while performing the duties of his/her employment? ☐ Yes ☐ No

3. Prior to this disability, number of hours worked per week: _____ .

4. Gross annual income [prior to disability]

   $ _____. If you are self-employed, your gross annual income is the average of your net earnings for the past two years.

5. Has policyholder returned to work? ☐ Yes ☐ No

   If no, date expected to return: _____ /_____ /_____ If yes, date returned to work: _____ /_____ /_____

6. If the policyholder has returned to work is he or she working ☐ Full-Time or ☐ Part-Time?

   If part-time, date expected to return to work full-time: _____ /_____ /_____

7. During the period of disability, is/was the policyholder earning at least 80% of his or her predisability salary? ☐ Yes ☐ No

Please complete this section only for W-2 Employees. (Contract 1099 or Self Employed worker; please see instructions.)

8. Are Disability Rider or Short-Term Disability premiums deducted from the policyholder's paycheck on a pre-tax basis?

   ☐ Yes ☐ No

9. Does the employer pay a portion of the disability premium for the policyholder? ☐ Yes ☐ No If yes, what percent?_____ %

10. Policyholder is: (Check all that apply.) ☐ Exempt from Social Security ☐ Exempt from Medicare ☐ Subject to RRTA
(Please contact payroll and/or check the policyholder's Salary Redirection Agreement/Premium Deduction Authorization card for the answer to this question.)

11. Date of hire: _____ /_____ /_____

12. Is the person still employed? ☐ Yes ☐ No If no, last date of employment: _____ /_____ /_____

Please note:
The employer is required to report disability benefits paid on pre-tax plans on Form 941 and the employee's Form W-2.

_____ _____ _____

EMPLOYER'S SIGNATURE TITLE DATE

_____ _____

EMPLOYER'S PRINTED NAME DIRECT PHONE NUMBER

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INITIAL DISABILITY CLAIM FORM – PHYSICIAN'S STATEMENT

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Policy Number: Policyholder's Name: _____

Patient Name: _____ Date of Birth: _____

SECTION C: PHYSICIAN'S STATEMENT (Must be completed by physician or physician's staff. If completed by a member of the physician's staff, then physician must sign the form) [continued on Page 4].

PHYSICIAN'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )	
MAILING ADDRESS	CITY	STATE	ZIP

Diagnosis description and ICD code: _____

If due to an accident, please give the date, details and location of the accident: _____

_____

1. Symptoms first occurred on: _____/_____/_____ If diagnosed with cancer, date of initial diagnosis: _____/_____/_____
2. Patient first consulted you for this condition on: _____/_____/_____
3. Was the patient referred to you by another physician? ☐ Yes ☐ No

   If yes, physician's name: _____

   Referring physician's address: _____ Phone number: _____
4. Was patient hospitalized as a result of this diagnosis? ☐ Yes ☐ No

   Admission: _____/_____/_____ Discharge: _____/_____/_____

   Hospital Name:_____

   City: _____ State: _____
5. Pregnancy claims: Date of delivery: _____/_____/_____ ☐ Vaginal ☐ Cesarean
6. If not delivered, expected delivery date: _____/_____/_____

   Please advise of any complications._____

   _____

INITIAL DISABILITY CLAIM FORM – PHYSICIAN'S STATEMENT

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Policy Number: Policyholder's Name: _____

Patient Name: _____ Date of Birth: _____

SECTION C: PHYSICIAN'S STATEMENT (Must be completed by physician or physician's staff [continued from Page 3].)

7. First date of disability: _____/_____/_____ Date patient was last treated: _____/_____/_____

8. Have you released the patient to return to work? ☐ Yes ☐ No

9. If patient has not been released to return to work, please provide the next appointment date: _____/_____/_____. Please also provide the date of expected release: _____/_____/_____.

10. If the patient has been released, please provide the date released: _____/_____/_____.

    Patient released to work: ☐ Full-time ☐ Part-time

    If part-time, please provide the date the patient is expected to return to full duty: _____/_____/_____.

11. If patient is not employed full-time, which Activities of Daily Living (ADLs) is the patient unable to perform?

    Check and **initial** all that apply: ☐ Continence ☐ Transferring ☐ Dressing
    ☐ Bathing ☐ Toileting ☐ Eating

12. Does this patient require direct personal assistance to perform these ADLs **each and every time?** ☐ Yes ☐ No

    If yes, how many days will the patient require direct personal assistance? _____

PHYSICIAN'S SIGNATURE DATE TAX ID NUMBER

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Claims Authorization to Obtain Information

AU

Instructions for completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant form:

1. **All areas of this form should be completed.**
2. **This form must be signed and dated by the claimant/patient below.**
3. **IMPORTANT: If you are filing a claim on behalf of a deceased, please check here**
4. **If you are the Authorized Representative, please sign below and indicate your relationship to the claimant/patient/deceased. In addition, include a copy of the legal document(s) authorizing you to act on their behalf.**
5. **Fax this form to 1-877-442-3522 or return the form to Aflac, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999, as soon as possible in order to expedite claim review.**

Policyholder Name:	**Policy Number(s):**	**Date of Birth:**
Policyholder Address:		
Claimant/Patient Name (if different from named policyholder listed above):		**Date of Birth:**

This authorization shall be valid for a period of two years from the sign date unless a lesser time frame is indicated. Alternate Expiration Date:	**Name and Address of health care provider(s), company, or individual authorized to release the requested information:** (this section will be completed by Aflac):
Purpose of Disclosure: Evaluate claims for benefits during the time this authorization is valid.	

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment, other insurance coverage, or any other nonmedical facts be released to **American Family Life Assurance Company of Columbus (Aflac)** or any person or entity acting on its part. This could include, but is not limited to, any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer.

I understand that:

1. Protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment, or the presence of a communicable or noncommunicable disease.
2. My treatment, payment or eligibility for benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to **Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999**, except to the extent that:
   a. Aflac has taken action in reliance to this authorization, or
   b. Other law provides Aflac with the right to contest a claim under the policy or the policy itself.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

Signature of claimant/patient, guardian or authorized representative **Date**

Printed name of claimant/patient, guardian or authorized representative **Relationship**